MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

APPLICATION FOR DIRECT PAYMENT

W.C. Injury Number
Medical Fee Dispute No.

Please check the appropriate box.

☐ **Authorization potentially in dispute**
☐ **Authorization has been provided** ☐ Original ☐ Amended

Use this form only if you are a hospital, physician or other health care provider that has provided services to an employee, which have been authorized in advance by the employer or insurer or where the authorization is potentially in dispute.

Please note that pursuant to § 287.140.13 (6) RSMo, the services provided must relate to a work-related injury under the workers' compensation law.

1. Health Care Provider Name	Address *(Street, City & County)*	State	Zip Code	Telephone No.

2. Employee (Patient's) Name	Address *(Street, City & County)*	State	Zip Code	Date of Accident/Occupational Disease
				Social Security No.

3. Name of Employer	Address *(Street, City & County)*	State	Zip Code	Telephone No.

4. Name of Insurer/Third Party Administrator	Address *(Street, City & County)*	State	Zip Code	Telephone No.

5.	Brief Description of Disputed Services Rendered	Date Services Provided	Name and Title of Person Who Authorized Services	Date Authorization was Given	Amount Billed	Amount Claimed
A.					$	$
B.					$	$
C.					$	$
D.					$	$
E.					$	$

Total Amount Claimed $ 0

(If needed, attach sheet with additional information.)

6. Signature of Health Care Provider*	Attorney Address	Attorney Telephone No.
7. Health Care Provider's Attorney Signature & Date*	Bar No.	Attorney Fax No.
	Attorney E-mail Address	

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Application for Direct Payment has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP

*** Please be advised that corporations and limited liability companies appearing before the Division must be represented by an attorney licensed in the State of Missouri. *See Reed v. Labor and Ind. Rel. Commn.*, 789 S.W.2d 19, 20 (Mo. banc 1990).**

*** If the Health Care Provider is a corporation or a LLC, and this Application is not signed by an attorney, this Application will be rejected.**